

Instructions: Fill out this form, have your manger sign it and then return to Staffing Office.

**NO CLAIM WILL BE PROCESSED UNLESS VERIFIED BY THE STAFFING OFFICE.**  
Failure to utilize this tracking form may result in a delay of your claim.

## Inappropriate Cancellation Notification Form

Name:  Union:  CNA  SEIU

Date of Occurrence:  /  /  Shift:  Day  Eve  Noc

Unit:  ICU  ER  ICB  7<sup>th</sup>  8<sup>th</sup>  9<sup>th</sup>  10<sup>th</sup>  OR  PACU  Other

**Details of Incident (Please Print Legibly):**

(Use Back of Form If more Space is Required). **DO NOT WRITE BELOW THIS LINE.**  More on Back

<b>Date Received by Manager:</b>	/ /	<b>Date Staff Member Filed:</b>	/ /
<b>Signature:</b>		<b>Signature:</b>	

<b>Investigation:</b>	<b>Staffing Clerk</b>

<b>Date Investigation Completed:</b> / /	<b>Recommendation:</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> W/O Merit
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**PAYROLL: DO NOT PAY THIS CLAIM UNLESS SIGNED BY STAFFING OFFICE MANAGER**

Investigator Initials	Verified By Staffing Manager	Control Number	Paid?	Payroll Enter Initials	Unit Director Given Copy
		-	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y